VAN LENNEP (Wm. B.)

Thirty-Fifth Year. FEBRUARY, 1887. Third Series, Vol. II., No. 2.

{Remarks on internal Urethrotomy

THE

North American Journal

OF

HOMŒOPATHY

In Certis Unitas.
In Dubiis Libertas.
In Omnibus Caritas.

PUBLISHED BY

THE JOURNAL PUBLISHING CLUB (Limited),

NO. 10 EAST 36TH STREET,

NEW YORK.

SUBSCRIPTION PRICE, PER VOLUME OF TWELVE NUMBERS, $3.00.
SINGLE NUMBERS, 30 CENTS.

Entered at the New York Post Office as Second-Class Matter.

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out an anæsthetic again for fear that this dislocated heart would stop altogether, and for analogous reasons I was not willing to resort to the use of ether. Everything indicated that this would be a good case wherein to test the action of the laughing gas. And it was administered with the happiest of effects. Under its influence the respiration became easier, deeper and slower, the pulse increased in volume, and there was less than usual of the cyanotic condition common to this form of intoxication.

Lest it shall be thought that I am fussy in the matter of my fears for this patient in case aspiration was repeated without an anæsthetic, I would refer the reader to the *Medical News* of January 1st, 1887, in which a case of sudden death, from aspiration, is reported by Reeve, of Ohio.

To summarize the foregoing :

I. Settle the diagnosis early by aspiration, removing enough fluid to render the subsequent use of anæsthesia safer.

II. Perform pleurotomy at once.

III. Use laughing gas for anæsthetic purposes, if attainable; if not, ether; but neglect no precautions.

IV. The site of the incision should be above the fifth rib.

V. Wash the pus out of the pleural cavity with warm water once.

VI. Inject the solution of hydrogen peroxide, diluted, to render the pus sweet and to check its production.

VII. Let the aperture close when pus ceases to be produced.

REMARKS ON INTERNAL URETHROTOMY, WITH CASES.*

By W. B. VAN LENNEP, M.D.,
Philadelphia.

EVERY originator of a new method of treatment or operation would seem to tend toward the extreme of too extensive application, would make the same a cure-all and an infallible one. He is met, however, by a host of opponents, incited, some by personal motives, others by jealousy, but the majority by the above mentioned tendency on the part of the inventor. These decry the same as useless, injurious, etc., in varying degrees, and it is only by the continued accumulation of testimony from disinterested observers that the procedure finds its real place. With this end in view, I propose to relate my experience with internal urethrotomy as devised and taught by Otis, of New York.

*Read before the Pennsylvania State Medical Society, September 23d, 1886.

I have practiced this operation for over two years, and have a series of nearly thirty cases observed for periods varying from the above down to a few weeks. They have been cut for the relief of gleety discharges, as a rule ; for troublesome symptoms of the prostatic portion occasionally ; and, in two instances, for almost complete closure of the urethra. The number of strictures has varied from one to six ; their location from one to four and a half inches down, the average depth of stricture following urethritis being, from my experience, between two and three or three and a half inches. Hence they have always been anterior to the triangular ligament, or in the superficial urethra, and readily reached by a straight instrument.

In two instances, there has been bleeding requiring attention subsequent to the operation, while but three have had more than the slight febrile reaction we might look for after any surgical interference. Cutting has been undertaken for hard, callous strictures, yielding only to a certain amount of dilatation, and then bleeding readily under manipulation ; for elastic, recontracting or resilient strictures, which stretch six or eight sizes, perhaps, at one sitting, but are back again to the starting point at the next. With but one exception, sounds and local and constitutional medication have always been tried first.

I have operated without any anæsthetic, with cocaine, and with ether, and would give the preference, other things being equal, to the latter, on account of the complete relaxation produced, and because cocaine has, in several instances, disappointed me.

The after treatment has with some been *nil ;* with others a course of sounding extending over a period of three weeks, during which the discharge of healing dries up. As a rule, the latter have done better. With this have been associated mild local applications of one form or another by means of injection, medicated bougie, or painting through the endoscope.

The majority of cases have been markedly benefited or cured of the troublesome symptoms ; in a number, too, I have been able to find a "catch" with the bulbous sound at one or more points cut. In some the symptoms recur with the recontraction, in others they continue in its absence. In some, they disappear when this constriction is removed by a second operation, in others they do not. I ought to add, in justice to myself, that this recurrence or failure, if you please, has not been more frequent in my earlier than in my later operations. A certain number of failures are undoubtedly due to follicular disease which often seems almost impossible to cure, unless, perchance, it be

kind enough to cure itself. A word concerning the technique of the operation may not be out of place.

The first step is to ascertain the full capacity of the urethra and accurately locate and measure the stricture or strictures. This is readily done with the urethrometer. The meatus and superficial constrictions are then cut to the full size with Otis' dilating urethrotome. I use this method almost entirely in enlarging the entrance to the urethra. The pressure seems to benumb the pain and the register enables one to be much more accurate than with the knife; the bleeding, too, is less troublesome.

The tightest stricture, usually the callous one, is then stretched and incised. My instrument registers one size too large, and in my later operations I have purposely overstretched and consequently over-incised the stricture. This is repeated if necessary until the urethrometer detects no "catch," and then the remaining constrictions, of which there are almost always one or more, situated anteriorly as a rule, are treated in a like manner.

It is hardly necessary to add a word in favor of cutting a tense stricture as compared with the older methods; Otis has argued the matter at length and in a convincing manner, to American surgeons at least.

In incising a stricture I take pains to have the knife look upward as nearly as possible in the median line. As a result the consequent bleeding is, to my mind, very much less, and in the two cases when bleeding was at all troublesome I neglected to do this.

Another precaution, and by no means an unnecessary one with the instrument in question, is to have the knives *literally* sharp. I once tried to operate with a dull knife, and since that time have them ground immediately after use.

The operation done, a large Nélaton catheter is introduced to the bulb and a warm antiseptic solution freely injected. It runs out alongside the catheter, of course, and very soon flows clear, however free the hemorrhage. This is repeated if necessary after each urination for from twenty-four to forty-eight hours. Bleeding usually accompanies the flow of urine and erections, but has, in every instance, yielded as readily to the washing as at the time of operating. The penis is gently bandaged, a folded napkin laid over it as a pad, which is held in place by a towel or bandage fastened front and back to a waistband, thus allowing the patient to make considerable pressure by traction on the same.

The account of a few cases may be of interest.

I. Mr. A., clerk, between 30 and 35 years of age, came to me in the summer of 1884 with a chronic but free urethral discharge and a left sided epididymitis. On the subsidence of the latter, I found, on examination, a clean cut, short constriction, a trifle over three inches down. It admitted a No. 27 (French) sound, and, to make a long story short, was, with considerable difficulty, gradually dilated to No. 36. In the meanwhile he had topical applications and several remedies.

The urethral capacity was full No. 45, but beyond No. 36 the stricture would not stretch, each sounding, too, being followed by free bleeding. To complicate matters, the epididymitis relapsed, and he was induced to try urethrotomy.

I operated with the patient under ether, and by two stretchings and cuttings brought the stricture up to No. 46. No other constrictions were present, and he recovered without a bad symptom and without after treatment. The discharge ceased, and nearly a year afterward I was unable to find any sign of stricture. This is the largest urethra I ever met with.

II. Mr. S., mechanic, æt. 33 years, was sent to me on account of symptoms that caused a suspicion of stone. I examined him carefully and made out a decided prostatic catarrh with extreme hyperæsthesia. He positively denied having had a urethritis, and I began with five drop applications of a five per cent. solution of nitrate of silver to the prostatic urethra, together with pressure to the same by means of cylindrical sounds. When I reached No. 29 (French) it was arrested at three and three-quarter inches, and I found there a hard, resisting constriction that refused any dilatation. The urethral capacity was found to be No. 35, the stricture measuring No. 28, while anterior to it was another of larger calibre. They were both cut and a No. 35 sound readily introduced; the patient being etherized, the deep urethra and bladder were carefully examined. There was next to no bleeding, the annoying perineal pains and dysuria disappeared, and the urine cleared up. On the second day, however, patient had a severe chill followed by high temperature (104 degrees) and a sweat. He received *aconite*, but the chill recurred with a sweaty fever and symptoms indicating *gelsem.* Still the fever continued with occasional chills and sweating at irregular intervals until it assumed a typhoid character. *Baptisia* seemed to clear up everything and he is now in a fair way to recover.

III. Mr. J., merchant, æt. 31, came under my care in January, 1885. He had had several attacks of urethritis, and, for a long time, had never been free from a slight urethral discharge, which seemed constantly inclined to spring into full bloom on the slightest provocation. He had been the rounds and tried everything. I found a contracted meatus, a constriction behind the fossa navicularis, a stricture through which a No. 30 sound could, with difficulty, be squeezed just short of two inches down, and another admitting a No. 27 nearly two inches further. Both constrictions would only give two or three sizes, while the urethral capacity was No. 37.

Using a four per cent. solution of cocaine as an anæsthetic, I brought them up to full No. 37, and the other day, fifteen months later, a No. 37 bulb went through the urethra as smoothly as it did immediately after the operation. There has been no recurrence of the discharge. Patient had two smart hemorrhages on the second and eighth days, following erections.

IV. Mr. C., salesman, consulted me concerning a urethral discharge he had been troubled with for about fifteen years, every over-exertion or sexual indulgence bringing on a profuse flow. His urethra measured No. 43, and, besides a contraction at the orifice, there were three strictures, approximately at one, two and four inches. They could be stretched with considerable force to No. 40, or even No. 41, but would bleed quite freely and require, at the next sitting, a No. 33 or No. 34 to begin with, so rapidly did they contract.

Urethrotomy was performed without an anæsthetic, at his request. At the first sitting I cut the two anterior strictures, freely over-incising them. At a second sitting, number three was treated in like manner. Still the discharge continued, and three months later I again cut a "catch" I found at stricture number two.

There was no apparent change in the flow, which still resisted every topical application and internal medication imaginable. I gave him, among other things, *hydrast. sulph.* as an injection, and, to my surprise, for it had hitherto always disappointed me, the discharge was checked at once. It recurs, however, to this day from the same exciting causes; it is bland, milky and profuse, unaccompanied by pain or inflammatory symptoms, and, from what I can learn, is non-infecting. About five months after the last cutting, I examined the urethra, but could find no sign of stricture.

V. Mr. M., sixty years old, contracted gonorrhœa when a young man, and used "very strong injections of nitrate of silver." He had noticed that, for some time, the stream of urine was getting smaller, and that he was obliged to use a good deal of force to expel the same.

I succeeded, with some difficulty, in getting the smallest filiform bougie into the urethra, and had to use considerable persuasion to make it advance. By degrees, a second was insinuated alongside, then a third, and so on until the urethrometer could be made to enter the canal. I found a capacious urethra measuring No. 35 or No. 36 up to within two and a quarter inches of the meatus; from that point on was a hard cicatricial tube. I cut up and down at several sittings, until I could readily pass a No. 35 sound. There was immediate improvement, which has continued, although the tendency to recontraction requires a stretching about once a month.

I would, in conclusion, heartily endorse internal urethrotomy in hard, callous strictures, which resist complete dilatation; in those which constantly contract, elastic or resilient ones. In tight stricture we must come to this procedure sooner or later in most cases. In

giving a prognosis, however, we must remember follicular disease, and, in rare instances, an atonic condition of the mucous membrane. We can, I think, perform the operation with every promise of success in cases of prostatic disease, catarrhal or nervous, when such a stricture exists in the anterior urethra.

I am decidedly opposed to internal urethrotomy beyond the bulb; hemorrhage is apt to be severe, and is hard to control, and reactions are frequent and dangerous. Further, the apparent constrictions in the triangular ligament, in many instances, certainly depend upon and disappear with the anterior strictures, while those of traumatic origin, so common in the membranous urethra, are best treated through a perineal incision.

SMALL-POX INOCULATION.

IN a lecture recently delivered at St. Mary's Hospital, Mr. Shirley Murphy adduced some evidence to show that there was a probability that the virus of small-pox obtained from the initial vesicle produced by inoculation of small-pox differed in its action from that obtained from the general eruption. The not infrequent death from inoculated small-pox led at first to much opposition to this method of protection against natural small-pox, but later it was found that inoculation could be performed without risk. In an account given by Sir George Baker of the extraordinary success attending the inoculations of Daniel Sutton, of Ingatestone, in Essex, who in three years inoculated some 20,000 persons without bad result, he attributed this success to the fact that Sutton allowed his patients to enjoy fresh air during their illness; while Dr. Glass, of Glasgow, believed that Sutton's treatment in encouraging perspiration was responsible for their recovery. It is clear that Sutton professed to have a secret in his treatment, although this secret is only metioned in relation to the composition of certain medicines; but Sir George Baker, curiously enough, observed that "What is extremely remarkable, he (Sutton) frequently inoculates people with the moisture taken from the arm before the eruption of small-pox"; and Dr. Chandler, who also witnessed Sutton's work, referred the chief benefit of his plan to the infecting humor being taken in a crude state "before it had been ultimately variolated by the succeeding fever." Baron Dimsdale, who took much interest in Sutton's proceedings, and subsequently himself practiced inoculation, closely imitated his method, and was very successful in his results. If, as Mr. Murphy pointed out, the virus of the initial vesicle differs in any respect from that of the general eruption, some difference may also be found in the ease with which the bovine animal is inoculated with the one and the other virus. Certainly this point deserves further investigation.—*London Lancet*, January 1st, 1887.